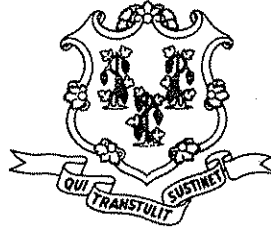


# State-Wide Primary Care Access Authority

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## Meeting Summary March 25, 2009

**Members Present:** Dr. Daren Anderson, JoAnn Eaccarino, Margaret Flinter, Dr. Robert McClean, Lynn Price, Tom Swan, Dr. Sandra Carbonari and Jody Rowell

**Also Present:** Tanya Court and David Krause

The meeting summary for the previous meeting were accepted.

Margaret Flinter stated that this meeting will focus on the workforce, pipeline, retention, and recruitment issues in primary care. She welcomed Tanya Court, Director of Public Policy and Programs for the Business Council of Fairfield County, who was invited to do a presentation on primary care access.

Margaret Flinter reported that the New York State survey was sent to the Department of Public Health (DPH) to be considered for use as part of the electronic licensure renewal program. She reported that Jennifer Filippone from DPH reported that reviewed the New York State survey and would consider incorporating them and that within the next two weeks she expects to send a draft document to the State-Wide Primary Care Access Authority for review.

Tom Swan stated that the HealthFirst Connecticut Authority approved the report to the Legislature on an 8-2 vote.

Dr. McLean asked if the vote was public record.

Tom Swan answered yes.

Dr. McLean asked who voted against the report.

Tom Swan responded that Brian Grissler, the CEO of Stamford Hospital, and Lt. Governor Michael Fedele voted no. He added that their reason for voting no was that there was no cost estimate for the plan. Many of the items that the State-Wide Primary Care Access Authority has been discussing have filtered into the report through the Quality Access and Safety Work Group and the Cost, Cost-Containment and Finance Work Group.

Tom Swan stated that we did not introduce one specific HealthFirst Connecticut Authority bill with the recommendations from the report. There are a number of pieces of legislation that incorporate significant aspects of the report. This includes; HB-6582: partnership pooling bill, HB-6600: Sustinet proposal, advanced by the Universal Healthcare Foundation, HB-6674: workforce development, SB-1049: banning of gifts to healthcare providers from the pharmaceutical industry, HB-6402: maximizing federal funds for Medicaid, HB-6417: Medicaid administration and services, SB-782: health information technology, SB-678: cost-containment and medical homes, SB-1079: health information network, and, HB-6675: increasing access to healthcare.

Tom Swan added that Legislative leaders met yesterday and have agreed to advance parts of the framework and position Connecticut well for any types of national reforms that don't cost money over the coming year. They have established a work group of committee leaders. Two of the committees that are leading it co-hosted a public hearing last month and heard a number of reform proposals. The leaders were very receptive and I am optimistic that we will see progress on this.

Margaret Flinter stated all these concepts are pieces of what was in the Health First report. Our report showed that the Northeast and Northwest were the two areas most likely to face a shortage of primary care providers. Both of those areas just received new access point funding, and new Federally Qualified Health Centers (FQHC) funding. The Torrington community health center received money to expand, and the Generations Corporation received money to establish a health center in Putnam, northeast Connecticut. The stimulus funding provides expansion for all of the community health centers across Connecticut.

Dr. Robert McClean stated that no one really knows how the stimulus money is going to flow since it has not been decided/stated how that money is going to be spent.

Dr. Sandra Carbonari stated that the electronic medical record (EMR) money is going to be funneled into Medicaid/Medicare practices, but it is all going to be retroactive. She added that there are two different EMR funds.

Tom Swan stated that Senator Williams has encouraging the state to develop a strategy around health information technology and making sure we maximize the impact of the stimulus finds in this regard.

Margaret Flinter commented on the patient-centered medical home hand-out and added that it is the best summary of all the patient-centered projects going on around the country. We may want to revisit this in terms of concrete recommendations. We also have the primary care

case management model around our Medicaid program but it also includes the private plans. We should be interested in all the people in Connecticut, in all settings, not just focusing on Medicaid population or any one population.

Margaret Flinter asked Tanya Court to share her thoughts on the workforce planning, development recruitment and retention issue at this point.

Tanya Court stated there is a genuine concern with having an adequate supply of doctors and allied health workers, particularly since the shortages have been predicted and it takes a while to train doctors appropriately. The factors that we have identified are faculty shortages, particularly in the community colleges, and the lack of clinical placements.

The Hospital Association Study showed that some areas of the state having serious problems. Southeast Connecticut clinical placement is a huge issue. Roughly 4,900 nurse placements were needed but hospitals could only offer 2,400. Training, class and lab space is an issue. Students receive inadequate preparation, particularly in urban areas, requiring remedial classes and increased time in school. There is a high turn-over rate in the community colleges, with students dropping out in the second year and then not being able to pass the nursing exam. Some graduates are not able to find placements, partially due to a temporary lull in expected retirements. This could cause policy makers to think that staffing is not a problem. The President of Bridgeport Hospital says this is a temporary lull, and that staffing will be a larger issue as people begin to retire and those spaces need to be filled. In addition, healthcare reform efforts will stress the system, as more people are brought into the system. Connecticut has some of the highest tuition rates in the country. This forces students to rely on student loans which become difficult to repay. In addition, there is a lack of data on healthcare workforce issues.

Dr. Robert McClean asked if Tanya Court was referring to nursing school.

Tanya Court answered that she is referring to community colleges and the undergraduate level. Based on the issues, we recommended the need to come up with a strategic healthcare workforce plan and to produce an annual healthcare workforce scorecard. Once there is agreement on the number of professionals needed, we set a target and measure to see what is going on. It is a way of focusing on the issue of the need to produce a certain number of doctors and nurses. DPH should take the lead in this and come up with a five year plan working with the local workforce investment boards. Also, a pilot program needs to be developed using web-based centralized clinical placement software. Currently, the agreements with hospitals on the clinical placements are archaic. Other states are using software. This will reduce the time needed to do the placements and when done online it will provide real-time information.

Dr. Robert McClean asked about the pipeline from community colleges into the nursing schools. He noted that much of this information was appropriate to HealthFirst, but not to PCAA and asked what our charge is relative to this information.

Margaret Flinter stated that Tanya Court spoke generally about recruiting the younger generation into health careers. We will include that as part of the Health First report and also support efforts to get people on the ground level into dentistry, social work, medicine, nursing and all of the health professions. Our task now is the primary care provider level.

Tanya Court stated that if we can keep people in Connecticut, either after high school or college, chances are their first job will be here and they will develop ties and become engaged with the community. I do believe we need to set targets and specific numbers for needed practitioners and then start measuring how we are doing. Without numbers there is no sense of urgency. This has been going on for a very long time.

Margaret Flinter stated that Bruce Gould stated that evidence has shown that the best chance of retaining a primary care provider in an area is to recruit them from that area.

Tanya Court asked if scope of practice may be an impediment to providing primary care. There was a study in Minnesota that looked at that. As a result they changed the scope of practice to deal with this in rural areas.

Tom Swan answered that this was something that we discussed at the last meeting. It is a real issue that is difficult to resolve. We don't have an answer at this time.

Lynn Price stated that she and Joann Eaccarino looked at the New York State survey. Much of that language translates easily to APRN's and we have included it in our recommendations. We looked at some of the issues Tanya mentioned, specifically, education, recruitment, and retention for APRN's. If we are going to attract people into the education programs, we need to provide generous loan payment or tuition reimbursement. Education in the health care profession is very expensive and we need some way to underwrite that for people who are in it. Even if we get increased reimbursement for primary care health services, I believe it will still never reach the pay levels for subspecialty. It has to be attractive for people to stay in primary care and possible for them to stay in business. We also want to recognize that in addition to the rural areas, the urban areas are also experiencing a decrease in primary care providers. There are reports of extremely long waits. There are other institutions such as correctional facilities, group homes, nursing homes, that need to receive primary care and have a very difficult time receiving it.

JoAnn Eaccarino stated that school-based health centers are really the answer for primary care for children.

Dr. Sandra Carbonari stated that school-based health centers are able to do a physical exam, but the child still needs primary care. The patient-centered medical home definition of primary care is that if that child gets sick when they are not at school, where do they go? They have needs other than what happens at school. It is certainly an important service but it is not enough. The school is not a primary care medical home setting.

JoAnn Eaccarino stated that things are done so differently in different communities that we cannot assume that a particular standard of care is happening uniformly.

Lynn Price stated that it seems that this is a structural issue. To some degree the model in which school-based care is provided could be adopted into a medical home model. The school-based care centers I am familiar with are actually part of a community health center so it is more seamless. I agree that it differs from community to community and that should be part of our recommendation that the model itself be examined for how it can better live up to its promise.

JoAnn Eaccarino stated that part of the solution is not to connect all school-based health centers to a community health center because that is very different depending on where you are. It is the choice of the parent and the community health center about what organization or entity is going to administer the school-based health center.

Dr. Daren Anderson stated that when we hear of an extremely long wait at a health center we immediately point to lack of access but there is also usually an underlying practice reform that needs to happen as well. There are well established principles of practice reform and advanced access. By reforming the way you manage your appointment flow, you can get people in sooner.

Tanya Court stated that this has come up frequently. Sometimes in order to schedule a regular physical the waiting time is six months. When you try to figure out why that is, it is because the primary care provider will only do a certain number of physicals per week so that they don't go broke. That is what is going on in our area with adults and children.

Dr. Robert McClean stated that frequently the physicians do not have enough control over their time or their practice. When the secretary says that there are three slots and they are filled for the next three months and there is a child that needs a physical for school, the doctor will definitely see the child. It is a system problem.

Dr. Daren Anderson stated that if we talk about payment reform and increasing Medicaid reimbursement that needs to come with some sort of string attached. There is something we want in return from the practices that are receiving increased reimbursement: better patient centered-ness and better customer service, advanced access principles, and shorter wait times.

Lynn Price stated that she agrees with this. In anything that we do here we need to recognize that it has multiple layers. There are other barriers to scope of practice. There are two ways of looking at scope. One is the legal definition of what a provider is allowed to do and the other is the scope that one is educated to provide. I would like to point out that there are problems that arise for non-physician providers. We are finding that other states recognize in statute that APRN's are primary care providers. I would ask that we consider that

Dr. Sandra Carbonari asked if we have the percentage of APRN's that go into primary care.

Lynn Price answered that we do not have state data but we do have national data. It is around 7%, nationally, go into primary care. Of that, about 30-33% works with vulnerable populations.

Jody Rowell stated that the behavioral health aspect of this is that under Medicaid currently, the enhanced care clinics received a 25% rate of increase; however, there is a 2-hour, 2-day, 2-week, requirement to receive those rates. So if a patient comes in and it is an emergent case then its 2 hours, if it is urgent then its 2 days, etc. We could look at that model when we talk about the reimbursement rate increase.

Dr. Daren Anderson stated that he fully supports the role of nurse practitioners as critical to the future of primary care. I also want to put forth that primary care physicians need to be part of that as well. Primary care has to be reinvigorated and is a critical piece of the puzzle in solving this problem. Fewer people are going into primary care now, largely due to economics. In any other westernized country in the world, at least half of their physicians are in primary care. They have a smaller difference between primary care physician pay and specialty pay. Payment reform and practice reform, with better support, care management and opportunities are what we need to make it a viable, stimulating and effective practice and career. There is no concrete data that nurse practitioners are taking and managing populations of patients that have chronic, complicated diseases, and doing as well with them. There is no data that states they are not doing well with them, but there is also no data that shows that they are equivalent to physicians. Without that data it is very difficult for the physician community to strongly support putting nurse practitioners on an equal footing, when looking at systems involving patient centered medical homes that require someone who is able to do more complex management and play the center role in that team management. The call for putting them on equal footing is not data supported. For that reason, I do not support it and the American College of Physicians does not support it, although it strongly supports collecting data looking into it.

Lynn Price stated that all parts are needed in the mix. There are different roles that need to be played in primary care. No one is suggesting that we don't need primary care physicians.

Tom Swan asked how big the problem is of people graduating from our nursing programs that don't have placements, and could that lead to real shortages in the future.

Tanya Court stated that we began to hear about this when the economy started to suffer. Right now there is a problem with graduating nurses finding placements. Right now it is just a temporary issue. What has happened is that the nurses are staying at the hospital, and not retiring as was projected. The placements are not easy to come by. What we are afraid of is that legislators will take that as a sign that the nursing shortage is not an issue that needs to be addressed. Nurses are going to retire, and they will need to be replaced. There is going to be increased access to healthcare which will also increase the need for nurses.

Tanya Court stated that the hospitals are trying to reduce their costs as well, so they are not hiring.

Dr. Sandra Carbonari asked if the problem is statewide, and if it is just hospital-based, nursing that is the problem.

Tanya Court answered that we are hearing from the nursing schools that many of their graduating seniors are not finding the placements they thought they would have. They may get placed, but it might be in a nursing home, not where they had originally wanted to be placed. We keep telling students that health careers are the way to go, it will not be outsourced, these are good jobs, and now there are no placements. It seems to be statewide.

Dr. Robert McClean stated that it would be easy to survey the hospitals and their human resources departments to see how many nurses have retired and been hired within the last two or three years. This would provide a sense of the flow in and out of the system. We don't have the data that is accurate. Talking to the nursing schools and getting anecdotal stories is not the most accurate way to accumulate data.

Tanya Court stated that we don't have the data. We are thinking of using money from the stimulus package earmarked for the workforce boards to finance summer programs for youth. The age span is 14-24, and 24 would be college graduates. What we are trying to do is provide an opportunity, like an internship, that will keep students in the state until they are able to find a more permanent job. We hope that this will give them an incentive to stay in Connecticut.

Tom Swan stated that this is something that we need to look at in figuring out the job pipeline and what are the challenges that we are facing in collecting data. As far as some of the structural changes in terms of practices, and looking to incentivize, we are not going to see an increase in reimbursement rates this year from the legislature. There is a greater acknowledgement that this is something that we need to look at in the coming years. If some of that \$634 billion dollars in Obama's stimulus package could be applied, it would be a big help. It is not going to come from the state at this point.

Dr. Robert McClean stated that higher reimbursement rates are needed to attract primary care physicians to see more patients and Medicare patients. Last year the legislature decided to increase reimbursement rates, which ended up increasing Medicaid rates 30-40%, which was still well below Medicare rates. Not many physicians decided to see more Medicaid patients. Hopefully, they will realize that this is not enough to solve the problem. It is thought that if Medicaid rates are made equivalent to Medicare then there will be more primary care physicians who are willing to see them. The problem is that you really can't pay into Medicare now. Medicare is a moving target, and is going down, or threatening to go down because of federal budget issues. Targeting a previous Medicare rate and making it a static number, not something that is going to move from year to year is a proposal that would give physicians some stability in knowing what they are going to be paid. If we are looking for what it is going to take as a recommendation to increase reimbursement rates to help better serve underserved patients then we need to be very concrete. At this point, Medicare rates do not remain stable for long periods of time, so targeting to a fixed rate would probably be more acceptable.

Tom Swan stated that people responded very positively when Health First pegged the reimbursement rate to Medicare. The exact terminology that was stated was the upper limits for Medicare. Things are in a state of flux so talking to people about increasing reimbursement

rates is a very difficult this year. The biggest success in rate reimbursement increase last year was the increase of dentists. We saw progress with that. The more it is tied to the type of structural changes that incorporate medical homes and primary care, the more success there will be.

Jody Rowell stated that it's not a panacea. Private insured patients have been forced out so that the enhanced care clinics can stay on top of what their requirements are to receive those rates. If we implement this we have to be careful not to force anyone out. In the long run in behavioral health, the private patients are calling and stating that they cannot find treatment because they don't have Medicaid.

Dr. Sandra Carbonari stated that the ECC's have stated that the system is not working. We don't want to use that as the end-all model. What is happening is that increasing access on paper doesn't necessarily increase the quality of care, number of patients seen. There are only a certain number of available providers. We have to keep the quality piece in mind.

Jody Rowell stated that she would like to come forth with the behavioral health recommendations at the next meeting. Primary care is very similar to behavioral health as far as access.

Tom Swan stated that he remains optimistic that we will move toward a much more ideal healthcare system over the next few years due to the work of this group and other groups like this one. The next meeting is scheduled for April 29, 2009. There should be some data back in terms of the work that the Health First Authority did. It would be good to try to have that be a joint meeting. We might try to have those meetings back to back. He thanked the committee for coming. The meeting was adjourned.